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Sex Education in the United States: Implications for Sexual Health and Health Policy

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Introduction

There is much disagreement over what constitutes effective sex education in the United States. There are several reasons why America's sex education system is outdated and problematic. First, it often advocates only for abstinence, which leaves people unprepared and unable to protect themselves if/when they choose to have sex, leading to higher rates of unintended pregnancies, abortions, and sexually transmitted infections in the U.S. than in any other developed nation in the world. In addition, the culture of fear surrounding sex education leads to negative attitudes among young people about sex. This can not only cause sexual dysfunction and strife in relationships, but also perpetuates the sex-negative view that personal sexual behavior is something to be controlled by a higher authority, be it parents of teenagers or government. Treating sex as something to be feared continues to fuel the American "sex panic," whereas treating sex as a natural part of life would encourage people to make more responsible sexual choices in the first place. This paper will demonstrate how sex education in the United States has negatively impacted sexual health and health policy.

Types of Sex Education

Abstinence-Only Sex Education

Abstinence-only (or abstinence-only-until-marriage) sex education programs seek to teach young people they must remain abstinent until they are married, as this is the only 100% effective way to prevent pregnancy and the transmission of sexually transmitted infections (STIs) (Malone & Rodriguez, 2011). In many of these programs, information about birth control and/or prevention of STIs is either completely absent or is only presented in terms of their likelihood of failure (Gardner, 2015). Additionally, curricula often exclude basic sexual health information relating to development, puberty, and reproduction (Starkman & Rajani, 2002). Abstinence-only

sex education programs are used in at least one-third of all U.S. school districts, leaving many students without basic knowledge of their own reproductive health (Doan & Williams, 2008).

While abstinence *is* the best way to prevent pregnancy and STIs, it is often unrealistic to expect adolescents to remain abstinent; on average, there is a seven-to-ten-year gap between the age of first sexual intercourse and marriage for people in the United States (Gardner, 2015). Surveillance studies have found that most adolescents are willing to risk negative sexual health outcomes in order to experience the pleasure and connection of engaging in sexual intercourse (Finer, 2007). By not providing accurate information about preventative measures to be used when sexual intercourse occurs, abstinence-only education programs leave adolescents at greater risk of negative sexual health outcomes (Schwarz, 2007). Furthermore, research has shown that abstinence-only education is highly ineffective; it does not result in abstinence behavior and teens who receive abstinence education are more likely to become pregnant when compared to those who receive comprehensive sex education (Carter, 2012; Stanger-Hall & Hall, 2011).

Comprehensive Sex Education

According to the Sexuality Information and Education Council of the United States (SIECUS; 2009), comprehensive sex education teaches age-appropriate, medically accurate information about contraceptives and abstinence, while also addressing the emotional, mental, physical, and psychosocial aspects of sexuality. Comprehensive sex education emphasizes the benefits of abstinence while also teaching about contraception and condom use, sexually transmitted infections, sexual orientation, puberty and development, safer-sex practices, anatomy and physiology, abortion, reproductive choice, relationships and emotions, and consent (Malone & Rodriguez, 2011; Starkman & Rajani, 2002). Comprehensive sex education has been endorsed by the American Medical Association, the American College of Obstetricians and Gynecologists,

the American Public Health Association, the American Nurses Association, and the American Academy of Pediatrics (Starkman & Rajani, 2002). Additionally, comprehensive sex education is widely supported by parents; given the choice, fewer than five percent of parents would remove their child from comprehensive sex education (Eisenberg, Bernat, Bearinger, & Resnick, 2008; Starkman & Rajani, 2002).

Many opponents of comprehensive sex education believe that providing it will increase sexual activity among adolescents (Johnson, 2016). However, studies demonstrate that providing information about contraception does not accelerate the onset of sexual intercourse, increase the number of sexual partners, or increase the frequency of sexual intercourse (Starkman & Rajani, 2002). In fact, comprehensive sex education programs which include information about both abstinence and contraception can reduce the number of sexual partners, reduce the frequency of sexual intercourse, and delay the onset of sexual intercourse (Starkman & Rajani, 2002). Given that nearly two-thirds of American youth are sexually active by the end of high school, and that the United States has the highest teen pregnancy rate in the developed world, it is clear that more needs to be done to provide America's teens with accurate, comprehensive information about sexuality and how to protect their sexual health (Guttmacher Institute, 2015; Starkman & Rajani, 2002).

History of Sex Education in the United States

Prior to the 20thcentury, there was little to no formal sex education in the United States (Huber & Firmin, 2014). In 1892, the National Education Association passed a resolution calling for "moral education in the schools," but it was not until the rampant spread of sexually transmitted diseases among soldiers during World War II that the federal government became involved in an effort to institute formal sex education in the United States (Cornblatt, 2009). The

1918 passage of the Chamberlain-Kahn Act allocated money to educate soldiers about gonorrhea and syphilis; this helped support organizations such as the American Hygiene Association, which taught soldiers about sexual hygiene throughout the course of World War II, and the Public Health Service, which coordinated with state health boards to prevent and control STDs (Cornblatt, 2009; Huber & Firmin, 2014). Following the success of these sex education programs in the military, schools began to integrate sex education into their curriculums in the 1920s, and these programs expanded over the next several decades (Huber & Firmin, 2014). Throughout the 1930s, 40s, and 50s, the resources available to educators expanded, with the U.S. Office of Education publishing materials and training teachers on how to teach about sexuality, and with many college campuses creating courses in human sexuality (Cornblatt, 2009). In 1964, Mary Calderone founded SIECUS, which sought to collect, develop, and disseminate accurate information regarding sexuality, as well as to promote comprehensive sex education and advocate for the right for individuals to make their own, responsible sex choices (Haffner, 1989).

While the early to mid-1900s saw significant growth, availability, and support for accurate sexual education resources, sex education became a political issue during the sexual revolution in the late 1960s and early 1970s (Cornblatt, 2009). This movement into the political sphere was greatly influenced by shifting attitudes regarding sexual behavior and morality, as well as by growing social tensions regarding legal issues such as access to birth control and abortions (Huber & Firmin, 2014). Despite growing political tensions, however, the AIDS pandemic of the 1980s garnered support for continued sex education, and by the early 1990s, all 50 states had passed mandates for AIDS education, which was often accompanied by general sex education (Cornblatt, 2009). At the same time, however, conservative groups began to advocate

for replacing sex education in schools with abstinence education, backed by the belief that abstinence is the only 100% effective way to prevent pregnancy and the spread of STDs, and that teaching about preventative methods would only encourage youth to engage in sexual activity (Huber & Firmin, 2014). As the religious right grew in political power in the late 1990s and early 2000s, so too did support for abstinence-only education (Malone & Rodriguez, 2011). In 1996, President Bill Clinton signed into law the Welfare Reform Act, which, among other things, allocated $50 million per year to state governments for the purpose of providing grants to abstinence-only sex education programs (Malone & Rodriguez, 2011). Forty-nine out of 50 states accepted this funding, which resulted in a massive increase in proportion of schools teaching abstinence-only sex education, raising the two percent of schools who implemented this approach in 1988 to 23% of schools in 1999 (Huber & Firmin, 2014).

In 2010, Congress eliminated two programs that funded abstinence-only education, and replaced them with the Personal Responsibility Education Program (PREP) and the Teen Pregnancy Prevention (TPP) Initiative, allocating $155 million to these evidence-based sex education programs (Fernandes-Alcantara, 2018). While implementation of these programs is a step in the right direction, abstinence-only education programs still receive a significant amount of government funding; the Title V Sexual Risk Avoidance Education program and the Sexual Risk Avoidance Education program still allocate $100 million per year to schools which provide abstinence-only education (Fernandes-Alcantara, 2018). The current political climate and upcoming 2020 election will likely play a strong role in influencing sex education legislation in the upcoming years.

Current State of Sex Education in the United States

As of 2019, 24 states mandate sex education and 34 states mandate HIV education (Blackman & Scotti, 2019). Thirty-seven states require that information about abstinence is provided, and 25 of those require that said information is emphasized (Hall, Sales, Komro, & Santelli, 2016). However, only 20 states require sex education to be factually accurate; only 18 states require providing information about contraceptives; and only eight states require sex education that mentions consent (Blackman & Scott, 2019; Hall et al., 2016; Barack, 2018). Furthermore, only 13 states require instruction to be medically accurate, only eight states require instruction free from race/gender bias, only eight states require inclusion of information for LGBTQ+ students, and only two states require that sex education does not promote religion (Hall et al., 2016). In 2016, the Center for Disease Control and Prevention (CDC; 2016) found that on average, high schools only require a total of 6.2 hours of sex education, and only two-thirds of that time is spent on providing information about HIV, other sexually transmitted infections, and pregnancy prevention. Fewer than half of high schools and only one-fifth of middle schools teach all 16 topics the CDC recommends as essential components of sex education (Demissie et al., 2015). Additionally, research has shown that only 33% of adolescent males and 57% of adolescent females reported receiving information about birth control before the first time that they engaged in sexual intercourse (Guttmacher Institute, 2016). Clearly significant changes are needed to make sex education in the United States more uniform, accurate, and helpful.

Growth and Development

One question when implementing sex education in schools is at what age this instruction should begin. The irrational fear of educators and administrators that teaching young people

about sex will cause them to have sex prevents providing young people with honest, developmentally appropriate sex education (Hauser, 2013). Unfortunately, this delay in instruction also too often results in students not receiving sex education until they have already become sexually active; 95% of Americans have sex before marriage and half of all youth begin having sex by the time that they are 17, so it is essential to start sex education early on in development so that adolescents have the resources they need to make informed decisions about their health (Culp-Ressler, 2014; Gardner, 2015; Hauser, 2013). This early education can help combat inaccurate information learned from unreliable sources such as peers or the Internet, and promoting conversation about sexuality early can help encourage open and honest communication about sex and sexuality between youth and the trusted adults in their lives (Hauser, 2013). Research suggests that in order to significantly decrease rates of sexually transmitted infections, unsafe abortions, maternal deaths, and unintended pregnancies, children should start receiving formal instruction on sexual health by the age of ten (Igras, Macieira, Murphy, & Lundgren, 2014). Gender identity and sexuality start to strongly emerge between the ages of 10 and 14, so it is especially important to target educational resources toward this demographic before they start experimenting with sexual behaviors (Igras et al., 2014). Starting sex education early can also help prevent sexual abuse and promote healthier relationships in later life (Rough, 2018).

There are additional benefits to starting sex education from an even younger age. Effective, comprehensive sex education includes more than just information about being sexually active; content about physical and social development, which is relevant to children of all ages, can begin as early as kindergarten. In early elementary school, children can be taught about the proper names for body parts, the difference between good touch and bad touch (which provides a

basis for consent), and ways they can build friendships (which sets the foundation for healthy intimate relationships in later life; Hauser, 2013). By fourth and fifth grade, it is appropriate for youth to learn about puberty and the changes their bodies are starting to undergo, Internet safety, and bullying (Hauser, 2013). Once students reach the seventh grade, they should begin to learn about body image, abstinence, reproduction, contraception, prevention of sexually transmitted infections, communication, and healthy relationships (Hauser, 2013). Following this general outline ensures that children are both learning the information that is necessary and relevant to their current development and that they are mature enough to comprehend the information they are being taught (SickKids Staff, 2019).

Opening up an honest dialogue about sexuality can help promote more positive sexual attitudes and healthier sexual behaviors later in life, too. One example of the success of an early and continuous model of comprehensive sex education is that of the Netherlands. Although teenagers in both America and the Netherlands start having sex, on average, at around the same age (17 or 18), they have dramatically different experiences with their sexuality (Rough, 2018; Sneen, 2019). American teenagers give birth at a rate more than five times that of teenagers in the Netherlands, and while young Americans constitute half of new STI cases each year, young people in the Netherlands account for only 10% of new STI cases each year (Rough, 2018). Dutch young adults also experience much more positive social experiences with sex: they tend to have less casual sex, report higher rates of sexual satisfaction, and communicate more openly with partners (Rough, 2018). Clearly, providing consistent comprehensive sex education from early on in life could help transform the sexual atmosphere and help promote much better sexual health outcomes in the United States.

The United States has seen some successful implementation of this early intervention, sex-positive approach to sex education within the last decade. *Get Real: Comprehensive Sex Education That Works* is a comprehensive sex education program designed for middle schoolers by the Planned Parenthood League of Massachusetts (Grossman, Tracy, Charmaraman, Ceder, & Erkut, 2014). This program includes 27 lessons distributed over the sixth, seventh, and eighth grades which provide age-appropriate, culturally-sensitive information focused on relational skill-building as a means to make healthy choices about sexual relationships (Grossman et al., 2014). A key feature of this program is that it also includes corresponding family activities (eight per grade) which build off of the school-based lessons, giving family members the opportunity to teach their own sexual and relationship values, as well as to increase family comfort in discussing topics related to sexual health (Grossman et al., 2014). The results of a study by Grossman et al. (2014) show that in schools where this program was taught, 15% fewer girls and 16% fewer boys had engaged in sexual intercourse by the eighth grade when compared to students who received the schools' existing sex education curriculum. Furthermore, the researchers found an additional delay in having sex among boys who completed the sixth grade family activities, suggesting that these activities encourage parents to talk to their sons about sex earlier and/or more often (Grossman et al., 2014). This highlights the importance of parental involvement in conjunction with school-based sex education, because schools and parents share the responsibility of educating and raising children, and the most successful lessons will be learned when they are taught and reiterated through as many avenues as possible (Pop & Rusu, 2015). Positive parental involvement in sex education also helps increase the network of trusted adults youth can turn to when they have concerns or questions about their sexual health, which further decreases the risk of negative sexual health outcomes (Pop & Rusu, 2015).

Issues of Diversity

LGBTQ+ Exclusion

Students in the LGBTQ+ community face sexual health inequities due to lack of community services, peer and parental support, and non-inclusive school sex education programs (Mustanski, Green, Ryan, & Whitton, 2015). LGBTQ+-inclusive sex education is not available to most adolescents; only 12% of students have had sex education classes that cover same-sex relationships and fewer than five percent of students have had health classes that include positive representations of LGBTQ-related topics (Human Rights Campaign, n.d.). Furthermore, three states require that only negative information is provided regarding non-heterosexual sexual orientations (Rabbitte & Enriquez, 2019). Aside from the obvious health benefits of helping LGBTQ+ students protect themselves against sexually transmitted infections and unintended pregnancies, LGBTQ+-inclusive sex education also socially benefits people of all sexual orientations, as it serves to normalize non-heterosexual sex and promote a better understanding of sexual diversity. This can produce long-lasting, positive societal changes by increasing acceptance and therefore decreasing bigotry and discrimination (Crowell, 2019).

It is especially important to provide comprehensive sex education to LGBTQ+ youth because men who sleep with men represent most of the HIV diagnoses in the United States, and lesbian and bisexual girls are at increased risk of teenage pregnancy (Mustanski, Newcomb, Du Bois, Garcia, & Grov, 2011; Saewyc, Bearinger, Blum, & Resnick, 1999). Additionally, LGBTQ+ youth are more likely to have sex at a young age, more likely to experience dating violence, more likely to have sex under the influence, more likely to contract sexually transmitted infections, and less likely to use protective health measures (Crowell, 2019). Discriminatory sex education policies also negatively impact the mental health of LGBTQ+

students, which in turn leads to lower GPAs and educational aspirations among LGBTQ+ youth, which can then produce or perpetuate feelings of isolation from the student community and higher rates of depression (Crowell, 2019).

Research suggests that because LGBTQ+ youth have a limited number of adults with whom they feel comfortable discussing sexual health, they often turn to peers or online sources for information; LGBTQ+ students are five times more likely to seek out online information about sexuality than heterosexual students (Crowell, 2019; Human Rights Campaign, n.d.). While the rise of the Internet and acceptance of LGBTQ+ individuals have certainly made information about LGBTQ+ sexual health more accessible than ever before, not all sources are necessarily medically accurate or age-appropriate, so it is essential to create a more reliable avenue through which LGBTQ+ students can get necessary information. Mustanski and colleagues (2015) developed an online, multimedia sexual health intervention program targeted at LGBTQ+ students called Queer Sex Ed consisting of five modules: understanding and accepting one's sexual orientation and gender identity, sexuality education, forming and sustaining healthy relationships, safer sex, and personalized sexual health improvement goals. A study on the efficacy of the comprehensive Queer Sex Ed program found it was extremely successful in increasing knowledge of sexual health topics among LGBTQ+ students; researchers found significant improvements in knowledge on the topics of sexual functioning, HIV and contraceptives, acceptance and understanding of sexual orientation, and healthy relationship skills (Mustanski et al., 2015). Additionally, participants in the study rated the program 4.2 out of 5 stars and expressed that they learned more from the program than they had ever learned in a school-based sex education program. This research shows that LGBTQ+ teens' tendency to seek out sexual health information from the Internet can be taken advantage of in

order to specifically target and educate these students. Federal and state policies are inconsistent and often difficult to change, so creating media resources for LGBTQ+ students can serve to bridge knowledge gaps and significantly improve health outcomes until public policy shifts to requiring a nationwide comprehensive model.

LGBTQ+ inclusive sex education is widely supported by parents; 78% of parents support discussion of sexual orientation in middle school, and 85% support discussion of sexual orientation in high school (Human Rights Campaign, n.d.). Unfortunately, public opinion is often not represented in state and school policies regarding requirements for sex education. Only 16% of states require that sex education include information specifically for LGBTQ+ students (Hall et al., 2016). In fact, several states mandate the utilization of discriminatory sex education practices which explicitly disadvantage and even discriminate against LGBTQ+ students (Crowell, 2019). In Texas, the public school sex education policy requires instructors to emphasize that "homosexuality is not a lifestyle acceptable to the general public and that homosexual conduct is a criminal offense;" this policy is based off of unconstitutional state legislation which was overturned by the Supreme Court in 2003 (Crowell, 2019). Several other states such as Arizona and Tennessee legally bar instructors from telling students if certain contraceptive methods are safe for non-heterosexual sex (Crowell, 2019). Other states have "don't say gay" policies wherein discussion about "alternate sexual lifestyles" and depictions of homosexual activity are not allowed (Crowell, 2019). There have been some positive shifts in sex education policy over the last decade: for example, when the Supreme Court legalized gay marriage in their ruling on Obergefell v. Hodges in 2015, abstinence-only-until-marriage sex education became more relevant for LGBTQ+ individuals, because prior to this case, these individuals could not legally marry, and therefore theoretically were expected to be abstinent

forever (Gardner, 2015). However, there is still a long way to go toward achieving equality for LGBTQ+ students in sex education.

Racial Discrimination

Children who do not receive any formal sex education are more likely to be black, and black children who do receive formal sex education are more likely to receive abstinence-only education (Masucci, 2016). Students of color also report very different experiences in sex education than white students (Hoefer & Hoefer, 2017). Black and Hispanic students report that the sex education they received was often based on assumptions that they were already sexually active and knowledgeable about sex; this incorrect assumption can lead educators to cater what they teach to a demographic which does not actually exist (Hoefer & Hoefer, 2017; Eisenstein, n.d.). Students of color at schools where their racial demographic represented the majority of students report receiving more comprehensive sex education and more information about contraceptive options than their white peers, but this stems from educators' assumptions that these students would not be capable of remaining abstinent (Hoefer & Hoefer, 2017). While this increase in comprehensive education may seem positive, the attitudinal suppositions behind it lead to students of color feeling like they are destined for failure in terms of maintaining sexual health; they feel they cannot seek out information on subjects about which they are uninformed because it seems their instructors expect them to already know about certain topics (Hoefer & Hoefer, 2017). These expectations on the part of educators often result in the omission of certain information about protection, which in turn leads to a self-fulfilling prophecy where students engage in sexual intercourse and experience negative sexual health outcomes due to lack of knowledge, therefore providing evidence for the initial flawed assumptions of educators (Hoefer

& Hoefer, 2017; Eisenstein, n.d.). Confronting this racial bias is essential in improving the sex education experiences of racial minority students.

SIECUS advocates that sex education can be used as a tool to advance racial justice (Eisenstein, n.d.). One way this can be accomplished is by acknowledging that there are systematic factors which disproportionately affect people of color, and that these serve as risk factors leading to higher rates of unintended pregnancies and sexually transmitted infections among people of color (Eisenstein, n.d.). Being aware of these factors can inform the design of more effective sex education programs by allowing for content creation which specifically addresses ways to combat these disadvantages and improve health outcomes (Eisenstein, n.d.). Another way to make sex education programming more relevant and relatable for students of color is to include materials that represent students of all races. For example, the majority of anatomical images shown in sex education programs are of white individuals; including images of more diverse individuals would be a fairly simple change that would help students of color feel more included in the course material (Eisenstein, n.d.). Representation of racial diversity in sex education courses can help promote equality and decrease racial stereotyping in future generations (Masucci, 2016).

Inherent Sexism

Another prevalent issue with sex education programs, and particularly abstinence-only sex education programs, is that they do not adequately address issues that disproportionately impact women and girls, such as sexually transmitted infections (LeClair, 2006). Between 1985 and 2005, HIV rates among women aged fifteen to nineteen more than doubled, even though rates overall have been declining (LeClair, 2006). Girls also experience higher rates of other sexually transmitted infections such as gonorrhea and chlamydia, and human papilloma virus

type sixteen—which has caused half of all cases of cervical cancer—is more than twice as prevalent in U.S. women as in men (LeClair, 2006).

Women are also disproportionately impacted by unintended pregnancies; not only can a woman's physical health be endangered during pregnancy, but women also face more significant financial and emotional burdens from carrying a child than the men who cause these pregnancies (LeClair, 2006). Negative outcomes from unintended pregnancies are even more severe in cases of unintended teenage pregnancy: teen mothers are more likely to end up on welfare and less likely to complete high school, and the children of teenage mothers are more likely to perform poorly in school and face abuse and neglect (LeClair, 2006). Furthermore, sons of teen mothers are more likely to end up in prison and daughters of teen mothers are more likely to eventually become teen mothers, themselves (Maynard & Garry, 1997; The Urban Child Institute, 2014). Abstinence-only sex education programs that do not teach about contraception endanger the health of women by withholding information which could help protect both their reproductive and overall health (Hoefer & Hoefer, 2017).

Another way that sex education programs negatively impact women is by promoting harmful or outdated stereotypes about female sexuality and by omitting information about female sexuality and pleasure (Geary, 2019). One example of such sexism in sex education is the ways in which virginity is discussed; it is often portrayed as a precious commodity that is physically painful to lose, and youth are often taught that girls should place high value upon their maintenance of virginity (Masback, 2016). This concept of promoting virginity is part of a larger dynamic of "slut-shaming," which is also perpetuated through teachings that women who masturbate, orgasm, and embrace their sexuality are sluts and whores, whereas boys are taught that their sex drive is natural and acceptable (Geary, 2019; Masback, 2016). Based on these

misogynistic stereotypes, girls and women are denied fundamental knowledge about their bodies. Sexism within sex education can make girls feel ashamed, which can lead them to be less likely to reach out to seek information regarding their sexuality and sexual health (Masback, 2016). Sex education should seek to promote sexual equality and combat the stigma surrounding female pleasure to further promote gender equality.

Conclusion

U.S. schools have the opportunity to prepare America's youth to make sexually responsible decisions as they are developing, and by not providing comprehensive sex education, they are failing America's teens (Beh, 2006). Evidence clearly shows that comprehensive sex education is not only the most successful method of education, but also the most cost-effective, safe, and well-rounded. Fewer than 50% of high school students and only 20% of middle school students receive instruction on all 16 essential topics of comprehensive sex education recommended by the CDC (Rabbitte & Enriquez, 2019). Furthermore, 55% of teenagers have turned to the Internet specifically for sexual health information, but what they find may or may not be realistic or medically accurate. Even when they're not looking for information, teens today spend a large portion of their time in front of screens, but the media they are consuming is often highly sexualized, which contributes to sexist attitudes, the exploitation of girls and women, and the societal tolerance of sexual violence (Mannion, 2014). The media has arguably become one of the leading sex educators for teens today, but that media is giving young people a warped view of reality–it can make certain risky behaviors seem normal, and gives viewers "scripts" of how to behave in new situations which may not be ideal or even safe (Strasburger, 2012). Impressionable teens are internalizing these harmful ideologies whether they realize it or not. The media proliferates gender roles and sexual stereotypes before youth have the knowledge

or skills to critically assess and challenge them (Mannion, 2014). Comprehensive sex education can serve as a counter to misinformation presented by the media.

Formalizing more comprehensive sex education can also help prevent the perpetuation of rape culture. Novack (2017) suggests that large-scale policy changes to educate students about acquiring consent can serve as a practical solution for reducing unwanted sexual contact. This has been established at several universities by implementing affirmative consent policies, which attempt to reduce sexual violence by shaping students' interactions in order to reduce ambiguity about sexual intentions and increase clarity of communication (Novack, 2017). One study found that receiving formal refusal skills training—how to say no to sex—as a part of comprehensive sex education in middle/high school served as a protective factor against being a victim of penetrative sexual assault in college (Santelli et al., 2018). If the fundamentals of consent are taught earlier on, it could serve to further reduce sexual violence and change societal attitudes to be less accepting of sexual violence.

One perplexing issue that needs to be addressed is the fact that public policy largely does not align with public opinion about sex education (Rabbitte & Enriquez, 2019). This disparity may continue to exist because in many cases, people are either not aware that it exists or because they feel like there is no way for them to affect change. In a study of Evangelical Christian parents in a town in Texas, Dent & Maloney (2017) found that despite abstinence-only sex education being a main goal of the Evangelical movement, the goals of individuals do not align with the goals of the movement. Rabbitte and Enriquez (2019) suggest that, as public health professionals, school nurses can play a large role in promoting comprehensive sex education to both parents/educators and to state legislators. The reality is that parents almost universally

support sex education, but politicians and other policy makers serve as barriers to policy change (Mannion, 2014).

There is a multitude of data demonstrating the benefits of comprehensive sex education, many of which have been discussed in this paper. Comprehensive sex education would have tangible positive effects on the well-being of people of all ages in the United States, and continuing to fund and perpetuate ineffective abstinence-only educational programs is tantamount to willing negligence of the well-being of our country's youth.

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